Consult Sheet

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Appointment Date:	**Appointment Time:**
Location:	
Patient Type:	
Gender:	
Social Security #:	
Alias:	
Requesting Provider:	

Chief Complaint / Diagnosis:	**Reason for Referral / Service Requested:**

Previous Treatment and Response (Include Meds):	**History of Illness / Injury with date of Onset:**

Current Medications:
Allergies:

Consulting Physician's Report
Significant Findings, Including Tests Done:
Diagnosis:
Orders / Recommendations:
Physician Signature: Date:

Physicians: If hospital admission is recommended / required, please notify CCS: 866-631-0176

Please include copy of Treatment Sheet upon release.

Place completed form along with all other documentation in a sealed envelope and send back with the Officer.

PATIENTS PLAN ESCAPES! DO NOT inform patients of the date/time of revisits or impending hospitalizations.

D19642DP50509PNXN

ER/IP Referral Form

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Sex	SSN	Custody Date	Potential Release Date

Alias:

Inmate Type: ☐ None ☐ State ☐ Interstate Compact ☐ Federal ☐ ICE/INS

☐ Is Juvenile ☐ Is Infirmary Housed

Requesting Provider: Provider Signature:

☐ Workers Comp ☐ Confirmed due to Inmate Violence ☐ Suspected due to Inmate Violence ☐ Pre-Existing Condition

☐ Inpatient Stay ☐ Prebooking Event ○ *Not Financially Liable* ○ *Financially Liable*

☐ Pre-Sentenced ☐ Sentenced

Category of Service: ☐ Emergency Room ☐ Direct Admission Hospital: _____

Means of Transportation: ☐ Custody Car ☐ Ambulance: ○ *911* ○ *Non-Emergency* ☐ Air Ambulance

Date of Service / Admission: **Discharge Date:**

Chief Complaint / Diagnosis:

Reason for ER visit: *Include date of onset, present treatment, history of injury or illness, include all x-rays and lab results with consultation*

Current Medications: _____

Allergies: _____

Vital Signs: **BP:** / **P:** **R:** **T:** °F **O_2 Sat:** % **Accu Check:**

Nurse Signature / Title: _____ Date _____ Time _____

ER Physician's Report

Please attach actual Emergency Room evaluation

Significant Findings, Including Tests Done:

Diagnosis:

Orders / Recommendations:

ER Physician Signature: Date:

Please include copy of ER Treatment Sheet upon release.

INMATES PLAN ESCAPES! DO NOT inform inmates of the date/time of revisits or impending hospitalizations.

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Emergency Response Worksheet

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Date of Birth	Today's Date

Chief Complaint: ☐ Medical ☐ Trauma ☐ Mental Health

History/Signs/Symptoms:

Allergies:

Medications:

Past Medical History:

Last Meal

Last Medication taken: Time:

ABCs ☐ CPR Required

Airway: ☐ Open ☐ Other

Breathing: ☐ Spontaneous ☐ Absent ☐ Shallow ☐ Labored ☐ Restriction ☐ Symmetrical ☐ Asymmetrical

Circulation: ☐ Carotid L/R ☐ Femoral L/R ☐ Radial L/R ☐ Dorsalis Pedal L/R

ASSESSMENT

Neurological: A V P U Orientation ☐ Person ☐ Place ☐ Time ☐ Event ☐ Not Done

Skin: ☐ Pink ☐ Pale ☐ Flushed ☐ Cyanotic ☐ Mottled ☐ Not Done ☐ Warm ☐ Cool ☐ Hot ☐ Dry ☐ Moist ☐ Diaphoretic

Pupils: ☐ PERRLA ☐ Sluggish ☐ Non-Reactive ☐ Un-Equal ☐ Not Done ☐ Constricted ☐ Dilated Size _____ mm

Trachea: ☐ Midline ☐ Deviated L/R Neck Veins: ☐ Distended ☐ Flat ☐ Not Done

Chest: ☐ BBS ☐ Clear L/R ☐ Wheezing L/R ☐ Decreased L/R ☐ Not Done ☐ Course L/R ☐ Absent L/R ☐ Crepitus L/R

ABD: ☐ Soft ☐ Rigid ☐ Flat ☐ Distended ☐ Not Done ☐ Pregnant Last Menstrual Cycle

Extremities: ☐ Moves all Extremities Well ☐ Ambulatory ☐ Not Done Lacks ☐ Circulation in ☐ Motor in ☐ Sensory in

☐ Not Done **TRAUMA ASSESSMENT**

☐ Deformities

☐ Contusions

☐ Abrasions

☐ Punctures / Penetrations

☐ Burns

☐ Tenderness

☐ Lacerations

☐ Swelling

Other:

Pain Index: 1 2 3 4 5 6 7 8 9 10 ☐ **Not Obtainable**

Disposition:

Date:

Time Health Care Arrived:

Time Code Called:

Location:

☐ Physician Notifiec

☐ Pt. to Clinic

☐ Ambulance

☐ **Hospital**

☐ Assessed/Release to Security

Glasgow Coma Scale

☐ Not Done

Eyes Open	
Spontaneous	(4)
To Speech	(3)
To Pain	(2)
Absent	(1)
Verbal	
Oriented	(5)
Disoriented	(4)
Inappropriate	(3)
Incomprehensible	(2)
Absent	(1)
Motor	
Obeys	(6)
Localizes Pain	(5)
Withdraws (flexion)	(4)
Decorticate (flexion) Rigidity	(3)
Decerebrate (extension)	(2)
Absent	(1)
Total (3-15)	

Baseline Vital Signs:

Time:

BP:

Pulse:

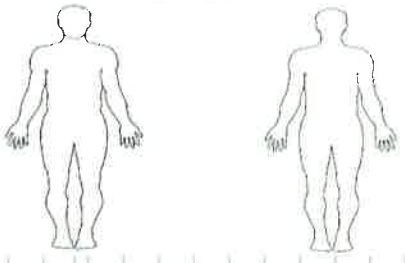
Resp:

Temp: °F

O_2 Sat: % RA

Blood Glucose:

AREAS OF INJURY



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Emergency Response Worksheet

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Date of Birth	Today's Date

Treatment

□ None provided
□O_2 @ _____L/min VIA □ Nasal Cannula □ NRB □Oral Airway □Nasal Airway
CPR: □ AED used □ Chest Compressions □ BVM
□ Bandaging Applied Specify:_____
Medications Administered:_____
Other Treatments applied:_____

Narrative Of Code Event

Time	Comments:

Responders

Medical	Security

Signature

Signature

Date

Off-site
Claims Form

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

Member ID# (9 digit PID #)
CUP _ _ _ _ _ _ _ _ _ _

Type of Transport ☐ ER ☐ Outpatient Appointment ☐ Other_____

Vermont DOC ❑

Billing Status (check one)

CBA Blue
PO Box 2365
South Burlington, VT 05407-2365
Electronic Payer ID 03036

Group #: 50702
Plan Code: 422/922


CBA Blue
Correct Care Solutions
Member Name
Member ID
CUP _ _ _ _ _ _ _ _ _ _
Group No: 50702
Plan Code: 422/922
This card does not guarantee benefits. CBA Blue provides administrative services only, and does not assume any financial risk with respect to claims.
Customer Service 1-888-222-9208
www.cbabluevt.com
Hours: M-F, 8 a.m.–7 p.m. ET
Send all Vermont provider claims to:
CBA Blue, P.O. Box 2365, South Burlington, VT 05407-2365, or Electronic Payer ID 03036.
Providers Outside of Vermont:
File claims with your local Blue Cross & Blue Shield Plan.
PPO

If patient becomes admitted, a claim to VHAP through the Z9 process should be submitted.

Federal ❑

United States Marshall Service
11 Elmwood Ave Ste. 601
Burlington, VT 05401

INS / ICE ❑

ICE Immigrations and Customs Enforcement
64 Gricebrooke Rd
St. Albans, VT 05478

Completed by: _____

The above inmate has been referred to your office for treatment.
Please bill the above checked entity for payment of services.

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CBA Blue is an independent licensee of the Blue Cross & Blue Shield Association, serving the business of Vermont. ® are marks of the Blue Cross & Blue Shield Association. CBA Blue assists in the administration of the Correct Care Solutions (in conjunction with the Vermont Department of Corrections) health care system. Correct Care Solutions is not affiliated with, nor are they a licensed entity of the Blue Cross & Blue Shield Association

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